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Idaho Department of Health and Welfare

Management Letter

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LEGISLATIVE AUDITS' MANAGEMENT LETTER

DEPARTMENT OF HEALTH AND WELFARE

PURPOSE AND SCOPE. In planning and performing our audit of the statewide *Single Audit* report of the State of Idaho for the fiscal year ended June 30, 2004, we completed certain financial audit procedures on the Department of Health and Welfare's financial activities that occurred during the fiscal year. The scope of work was limited to the Department's federal major programs as determined for the statewide *Single Audit*. Therefore, we considered the internal control structure to determine appropriate procedures and required tests, along with procedures performed at other State agencies, that would allow us to express our opinion on the statewide *Single Audit* report and not to provide assurance on the Department's internal control.

CONCLUSION. Although we include nine findings and recommendations, we conclude that the financial operations of the Department meet accepted standards and that the Department substantially complies with laws, regulations, rules, grants, and contracts for which we tested compliance.

FINDINGS AND RECOMMENDATIONS. The nine findings and recommendations presented below relate to the program indicated.

FINDING #1

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0305ID5028
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: N – Special Tests
Questioned Costs: Not determinable

Contract monitoring efforts are inadequate, resulting in errors, omissions, and delays in recovering Medicaid costs from private insurance resources.

Federal regulation (42 CFR 433.138) requires the Department to take reasonable measures to identify third parties who are liable to pay for services furnished by the Medicaid program. A liable third party is defined as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance" provided by the Medicaid program. (This finding focuses on the requirements to identify and recover costs from health insurance entities. A separate finding discusses the need for additional efforts to identify and pursue individuals as liable third parties.)

The Department relies primarily on the efforts of a contractor hired to perform these activities. The contractor's primary responsibility is to identify clients with health insurance coverage and bill the insurance for the medical costs paid by the Medicaid program. The contractor is paid a 10% commission based on the amounts collected. Our analysis of the contractor's efforts and activities disclosed the following:

1. Insurance data is not identified or entered promptly, if at all. There are significant delays identifying and entering insurance data, based on a comparison of client

eligibility dates, starting dates of insurance coverage, and dates when coverage was entered into the Medicaid payment system. A review of 1,373 clients with insurance resources active during June 2004 showed that insurance data was entered, on average, more than 180 days after the first opportunity to begin the coverage search. The delays ranged from three days to more than three years, with a median delay of 208 days.

Tests of collections received from providers showed that insurance resources known by the providers were not recorded in the Medicaid (AIM) system. Payments are regularly received from providers who were paid by an insurance resource that the contractor was not aware of, yet no efforts were made to obtain the insurance data from the provider.

2. Recoverable costs are not always identified and pursued. Clients for whom costs had been recovered from an insurance resource were reviewed to determine if all Medicaid costs paid were pursued. Many of the costs not pursued relate to services not covered by the insurance or were provided prior to or after the insurance coverage period. However, three clients (in a limited sample of ten) had recoverable costs that were not pursued. One client had nearly $9,000 in drug costs from July 2002 to October 2003 that were not pursued.

3. Commissions were paid on collections the contractor did not generate. Health insurance collections reported by the contractor for June 2004 were reviewed to determine whether these amounts resulted from contractor efforts. We estimate that at least half of the $356,468 reported for the month was voluntarily returned to Medicaid by providers. In nearly all collections tested, no insurance resource existed or was known at the time of the collection, indicating that no efforts could have been taken by the contractor to pursue these recoveries.

4. Activities were performed that were not described in the contract. The contractor sent hundreds of letters during fiscal year 2004 to select providers, informing them of insurance resources for services that had already been paid by Medicaid. The purpose was to give providers the opportunity to seek a greater reimbursement from the insurance resource and then refund the Medicaid payment to the Department. This process is not described in the contract "scope of work," and data to monitor the status and result of this effort was either not developed or not provided by the contractor. This

process may actually increase the amount of each claim recovered, but it raises the risk that recoverable amounts are not pursued at all or become stale waiting for providers to act upon the data and refund the Medicaid amount.

5. Accounts receivable increased significantly while collections decreased. Monthly reports and other data provided to the Department by the contractor showed significant increases in the accounts receivable balance, while monthly collections declined during fiscal year 2004. The accounts receivable balance as of June 2004 was $45 million, an increase of more than $13 million from the balance reported just six months earlier. During fiscal year 2004, total monthly collections steadily declined, from nearly $1.8 million during July 2003 to less than $450,000 during June 2004. Changes in claims processing occurred in January 2004, which could account for part of the decline in collections. However, the continued growth in Medicaid costs and the thousands of clients identified with insurance resources each month indicate that collections should continue to grow, but this is not the case.

Several contract requirements were not performed and essential reports and other documentation necessary to monitor and evaluate the contractor's performance were not prepared or readily available. Department staff was apparently unaware of the issues outlined above, because appropriate monitoring requirements were either not completed as required by the contract or were not established.

RECOMMENDATION #1

We recommend that the Department immediately strengthen the contract performance requirements and monitoring efforts to improve the results of the third-party insurance recovery efforts. These efforts should include developing processes to confirm that insurance resources are identified and recorded promptly, ensuring that all recoverable costs are pursued from the identified liable resources, and confirming that commissions paid to the contractor are based on collections resulting from the contractor's efforts.

We also recommend that the Department evaluate all collections reported by the contractor since July 2002, in order to identify and recover any unearned fees.

CORRECTIVE ACTION PLAN

The Department agrees that measures to determine contract compliance can be improved. The Department will review contract requirements and performance measures to determine any appropriate revisions to include, but not limited to, monitoring functions. The Department will review opportunities to increase the accuracy of coding of recovery payments posted/deposited

by other entities. The Department will continue to work with the Legislative Audit Office to resolve and clarify these issues.

1. Prompt Insurance Data Entry
   The Department tested a sample of data provided by the legislative auditor that was used as the basis for this finding. The test suggests that the information used in the formation of this finding may not have been complete. The Department will provide the tested sample data to the legislative auditor and will work with the auditor to determine the timeliness of the contractor entering third party resources.

2. Identify and Pursue Recoverable Costs
   The Department has not completed an analysis of the sample provided by the legislative auditor. The Department will work with the auditor to determine the extent to which there are unrecovered collections.

3. Commissions on Collections
   The Department reviewed the six examples provided by the Legislative Auditor. The Department's review potentially indicates a significant percentage may be the result of improper coding as health/medical insurance receipts, not casualty insurance receipts. The Department will work with the auditor to determine if there are commissions that were not earned according to the contract.

4. Activities Performed Outside the Contract
   The Department is currently working with the deputy attorney general's office to determine if all activities performed by the contractor are within the scope of the contract or if contract amendments are needed.

5. Accounts Receivable
   The Department agrees that the receivables held as potential recoveries identified in the contractor's system have grown over the past year. This is a result of two things:
   Move away from pay and pursue policy. The Department no longer pays up front and then pursues third parties. Instead, it forces the third party to pay the claim up front (whenever third party insurance resources are known) and then coordinates benefits within the policy limits of the private insurer and Medicaid.
   Not writing off uncollectible claims. The Department will work with the contractor to establish write-off criteria that maintains functionality for the business unit and more fairly represents the financial expectations of the program.

FINDING #2

CFDA Title: Medicaid
CFDA #: 93.778

The Department has not yet taken steps to pursue absent parents for reimbursement of ongoing Medicaid costs.

Federal Award #: 05-0305ID5028
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: N – Special Tests
Questioned Costs: Not determinable

Federal regulation (42 CFR 433.138) requires the Department to seek reimbursement of Medicaid costs from all liable third parties. A liable third party is defined by federal regulation (42 CFR 433.136) as "any individual, entity or program that is or may be liable to pay all or part of the expenditures" for medical assistance furnished under the Medicaid program.

The foundation of this issue is based on definitions and requirements described in federal regulations, State administrative rules, and procedures described in the Department's State Plan. Language also exists in nearly all new child support court orders indicating medical costs not covered by private insurance are partly the responsibility of the absent parent.

We recommended, in the fiscal year 2002 legislative audit, that the Department take steps to develop and implement a strategy to pursue and recover Medicaid costs from absent parents. These steps should include identifying children on Medicaid who have an absent parent, and seeking data from the child support program or other sources to locate the individual and pursue recovery of Medicaid costs. However, as of January 2005, no efforts have been made to pursue absent parents for ongoing Medicaid costs.

The regulations specify the actions to be taken, and require the Department to identify the paternity of all children receiving assistance and obtain data about the absent parent and their employer in order to recover the costs of services provided. Efforts to identify paternity and employer data can be coordinated with the child support enforcement program. However, the regulations clearly establish the Medicaid program's responsibility to identify all absent parents and other liable third parties, since many clients are not served by the child support program.

Administrative rules (IDAPA 16.03.09.031) further reinforce this issue by directing the Department to "recover payments for medical expenses from any liable third party, including a parent."

Nearly all current child support court orders include language that directs absent parents to provide health insurance and establishes their liability for a proportionate share of any costs not covered by the insurance. Since the Medicaid applicant is required to assign their rights to recover costs under the court order to the Department, we believe sufficient basis exists for the Department to seek Medicaid cost recoveries from absent parents without any further legal processes.

The statistics associated with this issue indicate a significant potential exists to recover Medicaid costs from absent parents. The following estimated activity (in rounded numbers) was gathered for June 2004.

121,000 children (under age 19) were enrolled in the Medicaid program
61,000 of these children have an absent parent
35,000 of these children have a child support case
25,000 have an existing court order for support

The legal responsibility and location of absent parents are known for most of these 25,000 cases, and many of the absent parents are financially able to cover the medical costs of their children. If only 10% of these cases were pursued, the Department could recover more than $6 million in Medicaid costs and possibly reduce future costs by encouraging absent parents to insure their children rather than risk potentially large recoveries. The effort to pursue absent parents may require additional resources that could be offset by the recoveries generated by this effort.

RECOMMENDATION #2

We again recommend that the Department develop a strategy to pursue and recover Medicaid costs from absent parents. This strategy should include methods for identifying all absent parents and opportunities to incorporate the Department's existing efforts and information in pursing these individuals.

CORRECTIVE ACTION PLAN

The Department consulted with federal officials about our authority to designate an absent parent as a liable third party resource. The Department shared this audit finding with CMS Region 10 during a November 2004 meeting; CMS Region 10 has not completed its research of this issue. The Department will contact CMS in order to obtain a follow-up response before taking action on this finding.

FINDING #3

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0305ID5028
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: Not determinable

Applications for and redeterminations of Medicaid eligibility are not processed within the required time frames.

Federal regulation (42 CFR 435.916) requires the Department to redetermine the eligibility of Medicaid recipients at least every 12 months. Procedures must be designed to ensure that recipients report any changes and that the Department act promptly to redetermine eligibility based on the new information. The Department must also process new applications within 45 days as required by administrative rules (IDAPA 16.03.01.103).

A random sample of 35 clients eligible for Medicaid benefits during June 2004 was made to determine the timing and basis used to determine eligibility. Four clients (11%) had not had

their eligibility redetermined within the last 12 months, and two of them were more than two years past due.

Applications are also not processed within 45 days as required. An analysis of pending applications as of February 2005 showed that 228 were submitted more than 45 days earlier, ten of which were submitted 90 days earlier, or more.

The delays in processing applications and redetermining eligibility are a result of the growth in the number of clients while resources have declined. The number of clients served has grown by nearly 10% annually over the past three years, overwhelming existing staff and delaying the development of new systems and other improvements. Each month, the Department processes applications for nearly 5,000 new clients and redetermines the eligibility of more than 13,000 existing clients. The Department has focused its efforts on the food stamp program during the past year to reduce error rates and potential penalties by the federal grantor in that program. This effort further reduced the resources available to process Medicaid applications and redetermine eligibility within the required time frames.

As a result, applications and redeterminations are not always processed within the time frames required, which delays eligible clients from receiving assistance while others remain eligible for Medicaid benefits in error. The amount of questioned costs could not be readily determined but could be substantial, given the number of errors in the cases sampled.

RECOMMENDATION #3

We recommend that the Department develop a strategy to comply with the time frames and requirements for processing applications and redetermining eligibility for Medicaid. This strategy should include establishing a quality control review process to identify training and process issues and limitations in existing automation.

The Department should also consider seeking additional resources and renewing its efforts to modify or develop automated processes to prevent or limit the opportunity for recurring eligibility errors.

CORRECTIVE ACTION PLAN

The Department agrees with this finding. The Department is pursuing additional staffing, improved quality assurance, and improved processes.

Caseload growth has resulted in large Medicaid caseloads. Staffing resources have not been adequate to accurately process and maintain the growing number of Medicaid recipients. The Department requested legislative approval of 43 positions in SFY05 and 40 positions in SFY06 (total of 83). The legislature approved 25 positions in SFY05 for eligibility programs (which include Food Stamps, Temporary Assistance for Families, and Child Care in addition to Medicaid eligibility) and 10 positions during SFY06 (total of 35).

The Department is working to improve not only the process of reviewing case files and timelines (as recommended) but ensuring that an integrated Quality Assurance process finds and implements more efficient and best practices to allow accurate and timely processing and maintenance of Medicaid eligibility.

The Department is also in the process of creating specialized business units to better handle the large eligibility caseload. The Family Medicaid Consolidated Unit will specialize in eligibility for CHIP B and Medicaid-only Medicaid. This unit will relieve traditionally field-based staff of approximately 37,000 Medicaid-only cases and allow them more time to work on timely application disposition and redeterminations of Medicaid eligibility. By challenging current operating procedures and practices and redesigning how Medicaid eligibility is done, the Department will improve services and accuracy as well as, make better use of limited FTP and budget appropriations.

FINDING #4

CFDA Title: Children's Health Insurance Program (CHIP)
CFDA #: 93.767
Federal Award #: 05-0305ID5028
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: $5 million (federal share of $4 million)

Eligibility continues to be improperly determined in one-third of the Children's Health Insurance Program (CHIP) clients tested.

Eligibility for CHIP is based on the following three basic situations. These requirements are established by federal regulations and the Department's federally approved State Plan.

Family income is between 100% and 150% of the poverty level
Other resources are less that $5,000
Private health insurance is not in force

The fiscal year 2001 audit report disclosed that 25% of children enrolled in CHIP did not meet all eligibility requirements. Eligibility was improperly determined in 14 of 53 clients tested, seven of whom were eligible for other Medicaid programs while the remaining seven were not eligible for CHIP or any other type of Medicaid.

The fiscal year 2003 audit report followed up on this issue and disclosed that errors continued to exist at nearly the same rate. Efforts were taken by the Department to modify the EPICS automated eligibility system and perform case reviews, resulting in a reduction of the number of clients enrolled in CHIP from 12,106 at June 2002 to 10,704 at June 2003. Total clients enrolled as of June 2004 were 12,046.

The current audit shows that errors in determining eligibility continue to exist. A test of 30 randomly selected clients enrolled during June 2004 showed that ten (33%) were not eligible for CHIP. Of these ten, eight were not eligible for any type of Medicaid benefit. Most of the errors were the result of miscounting income or resources, with four cases containing more than one error, such as excess income and having private insurance in force at the time of application.

A comparison of all 12,046 clients enrolled in CHIP in June 2004, with client health insurance coverage known by the Medicaid AIM system, showed that 1,239 (10.3%) had some

form of health insurance coverage in force during the month. Major medical coverage existed for 775 of these clients. In nearly all cases, insurance data existed at the time of application or at the annual redetermination date but was not considered in determining eligibility.

Most errors are the result of increasing case loads, declines in resources and staffing, and the use of outdated automated systems. Although the number of clients served from month to month appears to have leveled off, this comparison does not reveal the actual volume of work performed. During June 2004, the Department processed applications for nearly 2,000 new CHIP clients and redetermined the eligibility of more than 1,000 existing clients. Therefore, to increase the client count by just 118 from May to June 2004, the Department handled more than 3,000 clients through the application and redetermination processes during the month.

Additionally, there are no system edits in either the EPICS eligibility or Medicaid claim payment systems to identify CHIP clients who have health insurance resources. Policies are not in place to direct staff to search for insurance coverage in the Medicaid system at the time of application or during the annual redetermination. As a result, hundreds of ineligible clients are provided CHIP benefits.

Proper eligibility determination is crucial in providing CHIP benefits to only those in need. These errors could result in the repayment of more than $4 million to the federal grantor for the federal share of CHIP benefits provided to ineligible clients.

RECOMMENDATION #4

We again recommend that the Department review case files and remove ineligible clients from CHIP. Additional resources and renewed efforts are also needed to develop new automated systems and processes to limit the opportunity for recurring eligibility errors.

We also recommend that the Department negotiate a resolution with the federal grantor concerning the potential refund for the cost of providing services to ineligible clients.

CORRECTIVE ACTION PLAN

The Department agrees with this finding. The Department is pursuing additional staffing, improved quality assurance, and improved processes.

Caseload growth has resulted in large Medicaid caseloads. Staffing resources have not been adequate to accurately process and maintain the growing number of Medicaid recipients. Accurate eligibility, health insurance status, and correct coverage group are all areas that must be improved. The Department requested legislative approval of 43 positions in SFY'05 and 40 positions in SFY'06 (total of 83). The legislature approved 25 positions in SFY'05 for eligibility programs (which include Food Stamps, Temporary Assistance for Families, and Child Care in addition to Medicaid eligibility) and 10 positions in SFY06 (total of 35).

The Department is working to improve not only the process of reviewing case files and timelines (as recommended) but ensuring that an integrated quality assurance process find and implement more efficient and best practices to allow accurate and timely processing and maintenance of Medicaid eligibility.

The Department is also in the process of creating specialized business units to better handle the Medicaid-only and CHIP B caseloads. The Family Medicaid Consolidated Unit, to be located in Idaho Falls, will specialize in eligibility for CHIP B and the 37,000 existing Medicaid-only cases. We are also developing business processes that allow us to cross check information available in other Department systems (like AIM) with the eligibility system (EPICS) to ensure that eligibility determinations use information available with the Department (to support accurate eligibility determinations).

FINDING #5

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0305ID5028
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: B – Allowable Costs
Questioned Costs: Not determinable

Enforcement of administrative rules for Medicaid transportation providers needs improvement.

Federal regulations require the Department to provide Medicaid clients with appropriate access to medical services. This access includes providing transportation services to receive both emergency and non-emergency medical care. These regulations authorize the Department to establish administrative procedures, rules, and policies for providing transportation services that meet these requirements.

The cost for providing medical transportation services continues to grow, with increases in the number of clients, reimbursement rates, and units of service provided. Total emergency and non-emergency transportation costs over the last four years were:

FY 01	$10,323,146
FY 02	11,673,131
FY 03	11,885,427
FY 04	12,771,777

Non-emergency transportation providers are required under administrative rules (IDAPA 16.03.09.151) to maintain specific records, such as detailed travel logs, evidence that drivers are properly licensed, and that vehicles are registered and insured. These rules were established in March 2002 in response to the fiscal year 2000 legislative audit that identified potential overpayments, unsupported claims, and poor controls. However, these rules are not enforced and potential overpayments and other irregularities continue to exist.

Since the enactment of these rules, the Department has not requested any transportation provider to submit the required records, nor visited any provider locations to review these records. There are about 30 providers that comprise nearly 80% of the total non-emergency transportation costs. We requested nine transportation providers to submit their records for May 2003 to confirm compliance with administrative rules.

Only seven providers submitted records, and all lacked some level of information, such as complete logs, current vehicle registration, proof of insurance, or valid drivers' licenses. There were considerable inconsistencies on the detailed logs submitted when compared to claims paid, such as duplicate claims, trips for non-medical purposes, and no medical services provided on the day of the trip.

The Transportation Unit within the Division of Medicaid has three employees who are responsible for evaluating and approving "prior authorization" requests. These requests are based on the client's need for transportation services and are an effective tool to manage and control utilization and costs. However, resources are not available to enforce the administrative rules or perform additional analyses to identify potential overcharges or other irregularities. This limited evaluation disclosed inappropriate claims and issues that would not be identified under the current authorization process.

Also of concern is the lack of background checks and vehicle safety inspections as a condition of providing services to Medicaid clients. Some providers, such as taxi companies, are required by local jurisdictions to have each driver complete a full police background check, furnish medical certification, and show proof that the driver is at least 18 years of age. Quarterly vehicle inspection reports are also required, which include confirmation that proper seat belts and other safety features are installed in the vehicles. These requirements should be considered for all Medicaid transportation providers, given that unaccompanied children and vulnerable adults are transported by these providers.

RECOMMENDATION #5

We recommend that the Department enforce existing rules for non-emergency transportation providers. At a minimum, the Department should require that each provider submit copies of all drivers' licenses, vehicle registrations, and proof of insurance as part of the annual provider agreement renewal process.

We also recommend that the Department consider amending existing rules to require transportation providers to supply documentation annually, showing background checks for all staff and safety inspections of all vehicles.

CORRECTIVE ACTION PLAN

During the past year, there have been retrospective reviews to enforce existing rules for non-emergency transportation providers identifying over $35,650 in inappropriate provider billings. The Department will review enforcement mechanisms for any appropriate enhancements.

The Department will give consideration to amending existing rules requiring providers to supply documentation annually of staff background checks and vehicle safety inspections.

FINDING #6

CFDA Title: Child Support Enforcement
CFDA #: 93.563
Federal Award #: G0304ID4004
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: N – Special Tests
Questioned Costs: Not determinable

No procedures exist to identify or pursue child support debts from the estates of deceased non-custodial parents.

Federal regulation (45 CFR 303.6) requires the Department's child support enforcement program to take "any appropriate enforcement action" necessary to pursue and collect court-ordered amounts from non-custodial parents. A variety of methods and processes have been established by the Department to collect funds, including wage withholding, income tax refund offsets, and property liens.

One enforcement area not developed is pursuing the estates of deceased non-custodial parents. During fiscal year 2004, more than 230 cases were closed because the non-custodial parent died, but no efforts were taken to pursue the estate. In many cases, existing liens were released and efforts to collect from other sources were halted. We estimate that more than $1 million in court-ordered debts were written off, including more than $150,000 in debts owed to the State.

The child support procedures manual does not include any procedures for identifying or pursing the estates of deceased non-custodial parents. Caseworkers generally determine that a non-custodial parent has died by reviewing the local newspaper obituaries or from information provided by individuals involved in the case. Data from Vital Statistics and the Social Security Administration is available but may take several months after the date of death before it is provided to the caseworker. In some instances, caseworkers use genealogy Web sites to determine if a non-custodial parent has died in another state.

Once the death of the non-custodial parent is known, no procedures exist to guide the caseworker in pursing the estate. The procedures manual requires the caseworker to stop debt accruals and suggests that the custodial parent be referred to the Social Security Administration to seek survivor benefits for the child.

We found no evidence that child support debts have been collected from an estate or through a probate process. As a result, opportunities to collect child support and other fees directed by the court order are missed. The Department currently has an estate recovery program in place for the Medicaid program which could be used to pursue the estates of deceased non-custodial parents.

RECOMMENDATION #6

We recommend that the Department develop procedures for pursing child support debts from the estates of deceased

non-custodial parents through probate or other means. The Department should consider combining these efforts with the existing estate and probate recovery activities in the Medicaid program.

CORRECTIVE ACTION PLAN

The Department agrees with this finding. The Department is pursuing changes in its policy and seeking additional staffing to resolve this issue.

This is an area where the Department currently does not have a consistent policy or practice to pursue debts from deceased non-custodial parents. The Department is studying the requirements to implement necessary rules and procedures to pursue such debts. The ability to develop new procedures has been limited by Child Support's caseload growth and limited staffing resources.

The Department requested 25 additional positions from the 2005 legislature and was approved for 15 positions in SFY'06.

FINDING #7

CFDA Title: Child Support Enforcement
CFDA #: 93.563
Federal Award #: G0304ID4004
Program Year: October 1, 2002 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: N – Special Tests
Questioned Costs: Not determinable

Time frames are missed for providing services to interstate child support cases.

Federal regulation (45 CFR 303.7) requires the Department to provide child support services within specific time frames when working with interstate cases. The Department must respond to inquiries from other states within ten working days of receiving the request and must refer cases needing assistance from other states within 20 calendar days. As of June 2004, the Department had nearly 20,000 cases involving other states.

A sample of 30 interstate cases showed that 23 (77%) were not referred or responded to within the required time frames. In three cases, it took over a year to perform the required services. Several case files showed the delay was the result of staff waiting to obtain information from the client. Other cases had no evidence that efforts were taken to respond to or refer the case, as required. These delays are generally the result of large caseloads, the low priority placed on interstate cases, and misunderstanding of time frames for providing services.

As of June 2004, the child support program had more than 92,000 open cases assigned to approximately 120 caseworkers, resulting in an average caseload of nearly 800 per caseworker. Although some reorganization and restructuring has occurred to gain efficiencies, delays in providing services exist that reduce the effectiveness and success of the program.

RECOMMENDATION #7

We recommend that the Department develop a strategy to provide services to interstate child support cases within the required time frames. This strategy should include training that reinforces the time frame requirements for interstate

cases, and methods to reduce caseloads, such as reallocating or seeking additional resources and staffing.

CORRECTIVE ACTION PLAN

The Department agrees with this finding. Inadequate staffing resources and higher priorities in the child support program have resulted in delays in processing interstate child support cases. The Department is redesigning its child support process and is seeking additional staffing. The Department is working on a statewide re-design of consolidated child support processes that will identify a specific unit for interstate processing.

FINDING #8

CFDA Title: Temporary Assistance to Needy Families (TANF)
CFDA #: 93.558
Federal Award #: G0201IDTANF
Program Year: October 1, 2001 to September 30, 2003
Federal Agency: Department of Health and Human Services
Compliance Requirement: A – Allowable Costs
Questioned Costs: $1,831,578

The Department improperly used more than $1.8 million of the Temporary Assistance to Needy Families (TANF) Grant funds for inpatient treatment costs and child care services.

Federal funding under the TANF program is available for a variety of services to clients, if certain eligibility criteria are met. These criteria establish income guidelines and job search and work requirements the client must agree to as conditions for receiving assistance.

Federal regulation (45 CFR 233.145 (c)) prohibits the use of TANF funds for medical services for any type of "remedial care provided by an institution to any individual as an inpatient." In addition, the Department's federally approved State Plan and the associated administrative rules (IDAPA 16.03.08.376) prohibit the use of TANF funds for any type of child care.

An analysis of costs charged to the TANF Grant during fiscal year 2004 disclosed the following:

1. Inpatient services in the amount of $358,000 were incorrectly charged to the TANF program. The Department used TANF funds to provide services to children in group residential and mental health treatment facilities. These inpatient services included medical services, based on reviews of vendor invoices, that provided diagnosis and other information. These costs are unallowable to the TANF Grant, even if a portion of the costs are associated with room and board.

   Some confusion exists as to the limitations for these types of costs to the TANF Grant. Situations occur that require the placement of children in residential facilities that also provide mental health and counseling services. Other programs are available to fund these costs, such as the Children's Mental Health Block Grant or the Medicaid program, if the client meets the eligibility requirements. However, the costs of services for clients who receive medical services as part of a residential inpatient placement cannot be paid with TANF funds.

2. Child care costs of nearly $1.5 million were charged to

the TANF program in error. Near the end of federal fiscal year 2003, the Department determined that expenditures in the child care program would exceed available funding. As such, child care costs of $1,473,578 processed through the Idaho Child Care Program (ICCP) automated system during August and September 2003 were redirected to the TANF Grant. This was done by adjusting the accounting system coding and did not involve any client-level determination or other processes to document eligibility. No child care costs prior to or since this date have been charged to the TANF Grant.

All of the TANF child care transactions tested showed that eligibility had not been determined or documented as required by federal regulations. These costs are also in direct conflict with the State Plan, which prohibits the use of TANF funds for child care services. As a result, nearly $1.5 million of the TANF funds were used improperly, which could result in financial sanctions or refund to the federal grantor.

RECOMMENDATION #8

We recommend that the Department comply with federal regulations by not charging medical services or child care costs to the TANF Grant. Program staff should be notified that residential treatment placements that include any medical services are not allowable costs to the TANF program.

We also recommend that the Department contact the federal grantor to resolve the questioned costs and potential refund of federal funds.

CORRECTIVE ACTION PLAN

1. The Department disagrees with part 1 of this finding. The Department believes that the $358,000 of questioned costs represents expenditures that were made in accordance with the intent and letter of both the Federal Rules and State Plan.

   The Department believes that it is authorized to make the questioned expenditures under federal code (45 CFR 263.11) which provides a grandfather clause to allow the State to spend TANF funds in accordance to the State Plan that was authorized prior to 1995. The "grand-fathered" State Plan (IDAPA 16-0613) clearly authorizes the Department to make the payments in question.

   The Department also believes that the costs questioned by the auditor were allowable based on TANF rules. The Department's belief is based on reviewing the questioned costs that the auditor identified. The Department will work with the auditor and grantor to conduct a more detailed review of the nature and purpose of these expenditures to confirm the accuracy of the Department's belief.

2. The Department agrees that the actions taken by the Department may need further review but disagrees that the use of funds for child care is a questioned cost.

The TANF grant can be used to fund child care costs. Our federally approved State Plan, on page 6, under 'TAFI funded child care,' states that working families with a dependent child meet the definition of 'needy' for TAFI funded child care when their countable income is at or below 150% of the 1998 federal poverty guidelines. However, we acknowledge that the State Plan could be made clearer and the Department will amend the TANF State Plan at its next scheduled submission to clarify the ability to use TANF to fund child care.

The ambiguity and consequences of actions taken by the Department related to child care expenses funded by TANF should be discussed and evaluated with the federal grantor. The Department will contact the federal grantor and discuss both past practices and explore acceptable practices. The Department will document acceptable practices and processes to verify client eligibility when charging child care expenses to the TANF grant.

The federal citation identifying qualified state expenditures for TANF (to fund Child Care) can be found at: 42 USC § 609 (a) (7) (B) (i) (I) (bb).

FINDING #9

Contracting for information technology (IT) services is not cost effective when compared to hiring State staff.

State Issue

Several years ago, the Department outsourced most of the IT programming and maintenance services, partly to resolve Y2K issues, as well as meet the reductions in State staff required by appropriations. The availability of skilled computer programmers and IT professionals has improved significantly over the past several years, and the opportunity currently exists to hire these skills at a lower cost than current contracting rates. The limiting factor is executive and legislative authority to increase the number of full-time positions within the Department.

During fiscal year 2004, the Department paid $4.8 million to a contractor for 82,600 hours of IT system maintenance and programming services at an average cost of about $60 per hour. The bulk of services provided by the contractor involve existing program maintenance, which generally requires a basic or moderate level of ability and programming skills. Most of these efforts require skills and abilities similar to State classified job descriptions, with pay rates between $22 and $28 per hour. We estimate that the Department could fill 35 to 40 contractor positions with State staff and save in excess of $2 million annually.

Other benefits are also gained by in-sourcing IT services, such as stabilizing the knowledge base and developing career paths to fill upper level and senior management positions within the Department. Greater flexibility and control are also side

benefits that allow for a more dynamic and responsive effort to emerging issues.

The Department will continue to out-source some advanced skills and abilities for system development and modeling services. These services are not needed on a full time basis and are generally not available at current salary rates.

The need for IT services continues to grow as automation and new technologies provide opportunities to improve efficiency and accuracy. Purchasing all of these services through contracts is not cost effective when a large portion of these functions are routine in nature and could be performed with State staff at a lower cost.

RECOMMENDATION #9

We recommend that the Department reevaluate the IT programming and maintenance services contract and seek executive and legislative authority to replace contract personnel with state staff to reduce costs.

CORRECTIVE ACTION PLAN

The Department agrees that it could be cost effective to replace IT contract personnel with State staff. The concept was presented to executive and legislative authority with a request to begin implementation in the current fiscal year. The Department has received approval from both the executive office and the Joint Finance-Appropriations Committee to begin replacing 20 of the contract personnel. Depending on successful replacement of the initial 20 IT contractors, the Department may request approval to replace additional IT contract staff in the following year.

PRIOR FINDINGS AND RECOMMENDATIONS. The prior audit report covered fiscal year 2003 and included nine findings and recommendations. Following is the status of those recommendations.

PRIOR FINDING #1

Idaho's food stamp error rate has increased to 15% over the past several years and could result in federal sanctions on the State.

We recommended that the Department establish a plan for a long-term solution to reduce the food stamp error rate and avoid potential sanctions by the federal program. This could include reviewing current staff resources, reassigning existing resources, evaluating the cost-effectiveness of contracted staff, improving technology, additional training, and ongoing monitoring.

We also recommended that systems and processes used by other states be evaluated and possibly adopted to improve the accuracy and success of Idaho's food stamp program.

STATUS: OPEN

The payment error rate for August 2004 and the cumulative rate for federal fiscal year 2004 continue to exceed the national average, again raising the possibility of a financial sanction by

the grantor. The cumulative negative error rate (clients denied in error) is also higher than it was in May 2004. Additional resources, contract staff, and adjustments to reporting requirements have not yet improved accuracy and may signal the need for other strategies.

We continue to monitor the status of this issue and have recommended that the Department reevaluate the cause for errors and identify enhancements or other alternatives for reducing errors.

PRIOR FINDING #2

Additional options for recovering food stamp overpayments could be pursued.

We recommended that the Department study all options allowed by federal regulations for recovering overpayments and devise a plan to implement appropriate options, particularly for overpayments resulting from intentional client errors. Options should include, but not be limited to, seeking amendments to Idaho Code.

STATUS: CLOSED

The Department formed a work group to evaluate options for recovering food stamp overpayments and has concluded that additional options for recovering overpayments are not needed at this time.

PRIOR FINDING #3

No monitoring has occurred to ensure that Nutrition Education expenditures meet program objectives.

We recommended that the Department develop performance requirements, under the Nutrition Education contract with the University of Idaho, that follow the limits and intentions established by federal regulations.

We also recommended that the Department perform and document site visits, file reviews, and other monitoring efforts designed to ensure that program funds are used for appropriate services to eligible clients.

STATUS: CLOSED

The Department has initiated changes to the performance and monitoring requirements of the contract and assigned oversight of this program to the Contracts and External Resource Management (CERM) team. The team will perform site visits, file reviews, and perform other tests to ensure program objectives are met.

PRIOR FINDING #4

Errors in child support debt balances remain uncorrected for more than three years.

We recommended that the Department correct debt balance errors identified by the contractor, establish controls and limits to reduce the opportunity for financial errors, and coordinate these efforts with the new contractor to analyze and correct all child support debts. Processes are also needed to evaluate all debt balances annually for accuracy, and reassess recommendations of the contractor to prioritize and implement potential enhancements to the automated system.

We also recommended that the Department suspend the credit reporting process until procedures are in place that ensure debt balances are accurate and errors are corrected promptly.

STATUS: CLOSED

The Department has established a financial audit and policy team to coordinate and evaluate case audits with the contractor. The volume of case audits completed each month has not yet reached the intended level of 400, due to missing documents in case files, and the need for additional policies. As a result, ten temporary employees were added in October 2004 to enhance the efforts to obtain documents and clean up case files. The credit reporting process was adjusted with a new national electronic reporting system that began in October 2004.

Improvements have been made, but additional resources and time are needed to fully resolve this issue. We continue to monitor the progress for evaluating and correcting child support debt balances.

PRIOR FINDING #5

Additional federal funds are available if Medicaid costs for family planning services are identified.

We recommended that the Department identify the costs of family planning services in Medicaid claims since March 2003 and seek additional federal funds. Efforts are also needed to establish a process to identify and seek these additional funds on a quarterly basis.

STATUS: CLOSED

The federal grantor has determined that the method for identifying additional family planning costs is not adequately supported. Based on the limited amount of additional funds and efforts needed to identify them, the Department has terminated its efforts to collect this data or seek additional federal funds under the Family Planning Grant.

PRIOR FINDING #6

Eligibility for CHIP continues to be improperly determined in 20% of cases tested.

We recommended that the Department review case files and remove ineligible clients from CHIP. Additional resources and renewed efforts are also needed to complete development of the

new automated system to limit the opportunity for recurring eligibility errors.

We also recommended that the Department negotiate a resolution with the federal grantor concerning the costs for services provided to ineligible clients.

STATUS: CLOSED
(repeated in current finding #4)

Efforts were taken to identify and move clients enrolled in CHIP that should be in other Medicaid eligibility groups. A quality assurance program has also been established to review and monitor eligibility to reduce errors. Several adjustments were made to the EPICS eligibility system over the past several months, including enhancements to handle the new CHIP-B and ACCESS card programs. However, errors in determining eligibility for CHIP continue to exist as described in current finding #4.

PRIOR FINDING #7

The need or amount of adoption subsidies for hard-to-place children is not evaluated annually as required by Idaho Code.

We recommended that the Department perform annual evaluations that provide direct evidence of the continued need and amount of adoption subsidies. Efforts should include requiring adoptive parents to return a completed annual evaluation form. The Department should also consider reviewing other public records, such as vital statistics, school enrollment, or Social Security assistance payments to confirm the continued eligibility of the child.

STATUS: CLOSED

The Department implemented changes to its adoption assistance annual review in February 2004. Each family receiving adoption assistance benefits is now required to return an annual review form certifying they are still legally responsible for the child and that they are still in need of the adoption assistance benefits.

PRIOR FINDING #8

Errors in the cost allocation process omitted charges to the child support and food stamp programs.

We recommended that the Department include the child support and food stamp expenditures in the statistics used to allocate financial service costs. We also recommended that the Department correct monthly allocations for fiscal year 2003, which could generate $70,000 or more in additional federal funding.

STATUS: CLOSED

The Department changed the cost allocation program to include child support and food stamp transactions and posted adjustments to recover the additional federal funding in September 2003.

PRIOR FINDING #9

Funding for community-supported employment and related services is not coordinated or monitored.

We recommended that the Department seek funding to develop a comprehensive monitoring program for community-supported employment and related services. The monitoring program should identify all program costs, funding entities, and sources, and include efforts to coordinate services and contracts by various State agencies.

STATUS: CLOSED

The responsibility for oversight of employment services was transferred to the Department of Vocational Rehabilitation effective July 1, 2004. The Department agrees with the results of the audit and is participating in the Vocational Rehabilitation Task Force addressing the transfer of services and the audit findings.

AGENCY RESPONSE. The Department has reviewed this information and submitted its response, included as the corrective action plan sections of this report.

OTHER ISSUES. In addition to the findings and recommendations, we discussed other, less important issues which, if changed, would improve internal control, ensure compliance, or improve efficiency.

This letter is intended solely for the information and use of the Department of Health and Welfare and the Idaho Legislature, and is not intended to be, and should not be, used by anyone other than these specified parties.

We appreciate the cooperation and assistance given to us by the Department and its staff.

QUESTIONS CONCERNING THIS DOCUMENT SHOULD BE DIRECTED TO:
Ray Ineck, CGFM, Supervisor, Legislative Audits
Don Berg, CGFM, Managing Auditor

Report IC27004/SA27004/CA27004